STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. BUILDING _____ B. WING _____	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE AT LOFLAND PARK	715 E. KING STREET SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from August 30, 2011 through September 7, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and five (105). The survey sample totaled thirty-seven (37) residents.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tawonya Lennon, Ed. D., NHA | Administrator | 10/3/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 determined that the facility failed to develop care plans based on an identified need for 2 (R23 and R178) out of 37 sampled residents. Findings include: 1. Cross refer F318 Review of R23's admission information sheet dated 7/5/11 contained documentation from the receiving facility that R23 had contractures of her right hand. Review of R23's physician orders revealed an order dated 7/10/11 for "OT (Occupational Therapy) evaluation and treatment". Review of R23's care plans failed to contain a care plan developed with interventions for R23's contractures of her right hand. Review of R23's care plan with E16 (RN) on 9/6/11 at 2:20 PM confirmed the facility failed to develop a care plan for R23's contractures of her right hand. 2. R178 was admitted to the facility with diagnoses that included Alzheimer's Dementia with sun downing, gastrointestinal bleed with anemia and atrial fibrillation. The admission information provided by the hospital revealed R178 was 91 years old and had Alzheimer's Dementia for over 15 years. R178 had a loss of appetite and increased confusion. On 7/21/11 R178 was admitted to the hospice program. Review of R178's care plans revealed the facility failed to develop a plan of care for R178's end of life/palliative care status.	F 279	**Tag Number:** F279 **1. Resident affected by the deficient practice.** R23 care plan was updated per OT recommendations for splint & contractures. Splint schedule initiated on 09/07/2011. R23 was discharged to home with splint on 09/14/2011. **Other residents have potential to be affected.** All residents with contractures have the potential to be affected by the deficient practice. A facility wide audit will be completed to ensure residents with contractures have care plans in place for splints and/or ROM. **Systemic change.** Therapy will provide documentation to Unit Directors regarding any resident with contractures and recommendations for treatment. Unit Directors will verify care plan has been updated accordingly. **Monitoring.** 100% of residents with contractures will be audited for 3 months with further needs for continued audits determined through the facility QA committee.	09/07/11 10/07/11 09/30/11 12/07/11

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F 279	Continued From page 2 Review of R178's record with E18 (RN) on 9/6/11 at 10:00 AM confirmed the facility failed to develop a plan of care with interventions/approaches for R178's end of life/palliative care.	F 279	**Tag Number:** F279 **2. Resident affected by the deficient practice.** End of life/palliative care plan added for R178.	09/06/11
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews it was determined that the facility failed to provide services that included range of motion for one (R23) out of 37 sampled residents who was admitted to the facility with contractures of the right hand. Findings include: Review of R23's admission information sheet dated 7/5/11 revealed documentation from the discharging facility that R23 had contractures of her right hand. On 7/10/11 R23 was admitted to the facility with diagnoses that included right femoral fracture and bilateral knee amputation, and rheumatoid arthritis. Review of R23's physician orders revealed an	F 318	**Other residents have potential to be affected.** All residents admitted for hospice services have the potential to be affected. A facility wide audit of all hospice residents will be conducted and care plan follow up provided as needed. **Systemic change.** Education will be provided regarding need for nurse to initiate end of life/palliative care plan upon physician order received. Unit Directors will receive copy of hospice order and will ensure care plan updated appropriately. **Monitoring.** 100% of residents with hospice services will be audited for 3 months with further needs for continued audits determined through the facility QA committee.	10/07/11 10/31/11 12/07/11

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F 318	Continued From page 3 order dated 7/10/11 for "OT (Occupational Therapy) evaluation and treatment". On 7/12/11 an order was written "OT clarification order OT evaluation and treatment 5-6 times per week times 4 weeks for ADL (Activities of daily living) training, therapy, activities, and splinting right hand." Review of R23's OT assessment that was completed on 7/12/11 by E19 (OT) documented R23's short term goals were "#2 Pt. will tolerate appropriate right hand splint x 4 hours without skin irritation to decrease contracture development and improve hand position target 8/8/11" R23's long term goal was "#1 Pt will tolerate appropriate hand splint x 4-8 hours to improve hand position and decrease contracture development target 8/20/11". From 7/12/11 through 7/21/11 R23 had 9 OT sessions. On 7/21/11 a note was written " Patient reports having a splint in the past and that it didn't work. Patient reports disinterest in establishing a new splint for contracture prevention." OT services for R23 were discontinued including the provision of range of motion to R23's right hand. On 8/30/11 an interview with E17 (RN) revealed R23 had contractures of her right hand and did not have a splint nor did she receive range of motion for her right hand. During the interview E20 (Assistant Physical Therapy) walked by and stated that therapy identified today (8/30/11) that R23 was not receiving range of motion so they "picked her up today". Review of the 8/30/11 Plan of treatment provided by OT and developed by E10 (Program Director) revealed "#5Pt. will tolerate RUE (right upper	F 318	**Tag Number:** F318 **Resident affected by the deficient practice.** R23 care plan was updated per OT recommendations for decreased ROM & splint. R23 was discharged to home with splint on 09/14/2011. **Other residents have potential to be affected.** All residents with contractures have the potential to be affected by the deficient practice. A facility wide audit will be completed to ensure residents with contractures have care plans in place for splints and/or ROM. **Systemic change.** Therapy will provide documentation to Unit Directors regarding any resident with contractures and recommendations for treatment. Unit Directors will verify care plans have been updated accordingly. **Monitoring.** 100% of residents with contractures will be audited for 3 months with further needs for continued audits determined through the facility QA committee.	09/07/11 10/07/11 09/30/11 12/07/11

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F 318	Continued From page 4 extremity) hand splint x 4 hours with no complaints of discomfort and no signs or symptoms of skin integrity concerns for further contracture prevention." An interview was conducted with E10 (Program Director) on 9/6/11 at 2:25 PM which confirmed there was no documentation indicating R23 was provided range of motion for her right hand from 7/21/11 through 8/30/11. E10 stated that R23 was discharged from OT on 7/21/11. E10 continued to state that R23 was reassessed on 8/30/11 that identified R23's desire for a splint for her right hand so she could hold a paint brush. When asked where the splint was E10 stated R23 needed to be assessed with range of motion for the proper splint to fit her hand. When asked if a splint was ordered during the 9 sessions R23 received in July E10 stated "no". On 9/7/11 at 8:55 AM an observation was made of R23 which revealed R23 did not have a splint on her right hand. When R23 was asked about the splint for her right hand she stated she was waiting for the facility to provide her with a splint. She continued to state she never had a splint on her right hand and has not refused a splint for her right hand. R23 stated she wanted to be able to hold a paint brush and paint.	F 318		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 5 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R214, R48, R177 and R23) out of 37 sampled resident it was determined that the facility failed to monitor the effectiveness and side effects of psychoactive medications. Findings include: 1. R214 was admitted to the facility on 8/23/11. The facility's guidelines for use of behavior and psychoactive flow sheets indicated that residents on psychoactive medications would be monitored for potential side effects and have the problem or inappropriate behavior monitored. This included the use of a behavior flow sheet that identified the specific behavior known to the resident or those	F 329	**Tag Number:** F329 **1. Resident affected by the deficient practice.** R214 discharged from facility on 09/05/11. **Other residents have potential to be affected.** All residents on psychoactive medications have the potential to be affected. Education will be completed by clinical staff via self learning packet (SLP) on medication safety to include policy & procedures regarding psychoactive medications. **Systemic change.** Admission checklist revised to include tasks for follow up on psychoactive medications for new admissions. New orders for psychoactive medications provided to Unit Directors to ensure appropriate monitoring of behaviors, side effects & monitoring in place. All nurses will complete Medication Safety SLP. **Monitoring.** Weekly reviews of psychoactive medications with audits for monitoring specific behaviors, side effects & medication effectiveness will be conducted for 3 months.	10/31/11 10/31/11 12/07/11

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F 329	Continued From page 6 commonly associated with the diagnosis. Staff were instructed to indicate the number of occurrences of each identified behavior each shift. The August 2011 MAR (medication administration record) included ativan (anti-anxiety medication) 0.5 mg daily as needed for anxiety/agitation. The resident's care plan for anxiety related to shortness of breath, illness and agitation included the approaches; -Document s/s of anxiety q shift -Monitor behaviors/side effects related to anti-anxiety medication. Review of the record did not include what behaviors R214 exhibited when she was anxious. The ativan was administered on 8/23, 8/24, 8/25, 8/27, 8/28, 8/29, and 8/30/11. A nurse's note documented the administration and effectiveness on 8/24/11. The administration on 8/27/11 at 2 AM was the only dose documented on the back of the MAR under indication for use as restless/agitation. No results were documented. The remaining doses of ativan did not have documentation of indication of use or effectiveness. No behavior monitoring sheets were found for the resident's anxiety. The August 2011 MAR included ambien (hypnotic) 5 mg as needed for insomnia. The resident's care plan for insomnia related to	F 329	**Tag Number:** F329 **2. Resident affected by the deficient practice.** AIMS test completed for R48. **Other residents have potential to be affected.** All residents on psychoactive medications have the potential to be affected. Education will be completed by clinical staff via self learning packet (SLP) on medication safety to include policy & procedures regarding AIMS testing. **Systemic change.** Long-term care residents receiving psychoactive medications will be reviewed monthly at facility Behavior/Psychoactive Medication Meeting for AIMS completion dates. Admission checklist revised to include tasks for follow up on psychoactive medications for new admissions. New orders for psychoactive medications provided to Unit Directors to ensure AIMS test completion. All nurses will complete Medication Safety SLP. **Monitoring.** Audits will be completed monthly for 3 months for all residents receiving psychoactive medications requiring AIMS testing.	09/01/11 10/31/11 10/31/11 12/07/11

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F 329	Continued From page 7 anxiety and shortness of breath included the approach; -Administer medications as prescribed for insomnia. Assess benefit and for any side effects. The ambien was administered on 8/24/11 at 1 AM and 8:30 PM, 8/29/11 and 8/30/11. The only dose documented on the back of the MAR for use and effectiveness was the 8/24/11 at 8:30 PM dose. An interview on 9/6/11 at 9:30 AM with nurse E6 revealed that behavior sheets are not used on all residents and the use and effectiveness of the ativan and ambien should have been documented on the back of the MAR. 2. The facility's AIMS (abnormal involuntary movement scale) testing policy documents that the AIMS test will be conducted for any resident receiving an anti psychotic medication upon admission or initiation for the medication and every six months thereafter and as indicated. R48 was readmitted to the long term care facility on 7/11/11 after a stay in a psychiatric facility. The resident had orders for the anti psychotic seroquel 75 mg in the morning and 100 mg at bedtime. Interviews with the unit manager E21 on 9/2 and 9/6/11 revealed that no AIMS testing could be found for the readmission on 7/11/11 or in the resident's record prior to the psychiatric hospital admission. The facility did an AIMS test on 9/1/11 once it noted one to be missing. 3. R177 was admitted on 4/5/11. On 6/9/11 the physician ordered the anti psychotic medication	F 329	**Tag Number:** F329 **3. Resident affected by the deficient practice.** AIMS test completed for R177. **Other residents have potential to be affected.** All residents on psychoactive medications have the potential to be affected. Education will be completed by clinical staff via self learning packet (SLP) on medication safety to include policy & procedures regarding AIMS testing. **Systemic change.** Long-term care residents receiving psychoactive medications will be reviewed monthly at facility Behavior/Psychoactive Medication Meeting for AIMS completion dates. Admission checklist revised to include tasks for follow up on psychoactive medications for new admissions. New orders for psychoactive medications provided to Unit Directors to ensure AIMS test completion. All nurses will complete Medication Safety SLP. **Monitoring.** Audits will be completed monthly for 3 months for all residents receiving psychoactive medications requiring AIMS testing.	09/25/11 10/31/11 10/31/11 12/07/11

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F 329	Continued From page 8 seroquel 25 mg daily to treat behaviors related to dementia. There was no evidence that an AIMS test was conducted upon initiation of the medication. An interview on 9/2/11 with the unit manager E7 revealed that no AIMS test could be found. 4. R23 was admitted to the facility on 7/10/11. a. On 7/12/11 R23 had a physician order for "Ativan 1 mg by mouth prior to HBO (hyperbaric oxygenation) treatment." The resident's care plan for Anxiety related to HBO treatment with approaches that included: -document signs and symptoms of anxiety every shift -monitor behaviors/side effects related to anti-anxiety medication. Review of R23's medication administration record and controlled medication utilization record revealed R23 was administered Ativan in the morning before her treatments and on 10 different occasions in July 2011 she received additional doses of Ativan at night between the hours of 8:00 PM and 11:30 PM. On 8/1/11 R23 had a physician order for Ativan 0.5 mg every 8 hours as needed. Review of the record did not include what behaviors R23 exhibited when she had anxiety. No behavior monitoring sheets were found in the record. Review of R23's nurses notes documented on 8/25/11 at 12:00 PM revealed "medicated with	F 329	**Tag Number:** F329 **4a. Resident affected by the deficient practice.** Physician was contacted regarding R23 Ativan order, which was changed on 08/01/11. R23 was discharged home on 09/14/11. **Other residents have potential to be affected.** All residents have the potential to be affected. Education will be provided to correct deficient practice. **Systemic change.** All nurses will complete Medication Safety SLP which includes medication correctness, administration, indication & effectiveness. **Monitoring.** Monthly random audits will be completed for as needed medications for 3 months.	10/31/11 10/31/11 12/07/11

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F 329	Continued From page 9 Ativan 0.5mg for insomnia." Further review of R23's clinical record revealed the facility failed to monitor R23's behaviors that required the Ativan use. Review of R23's record and concerns with E16 (RN) on 9/6/11 at 12:30 PM confirmed R23 was not administered the Ativan as ordered. R23 should not have been administered the extra doses of Ativan at night in July 2011. E16 stated that HBO treatments are only given during the day Monday through Friday. She continued to confirm that the facility failed to monitor R23's use and effectiveness of the Ativan. b. On 7/10/11 R23 had a physician order for Ambien 10 mg one po every night at bedtime for insomnia. The resident's care plan for Insomnia related to hospitalization, anxiety included the approach; -Administer medications as prescribed for insomnia. Assess benefit and for any side effects medications:Ambien 10 mg at bedtime. Review of R23's medication administration record revealed R23 was administered the Ambien at bedtime from 7/10/11 to present. The nurses notes occasionally documented that the Ambien was administered for insomnia. Review of R23's record revealed the facility failed to consistently monitor and document the use and effectiveness of the Ambien for R23's insomnia. Review of R23's record with E16 (RN) on 9/6/11	F 329	**Tag Number:** F329 **4b. Resident affected by the deficient practice.** R23 was discharged home on 09/14/11. **Other residents have potential to be affected.** All residents have the potential to be affected. Education will be provided to correct deficient practice. **Systemic change.** All nurses will complete Medication Safety SLP which includes medication correctness, administration, indication & effectiveness. **Monitoring.** Monthly random audits will be completed for prn medications for 3 months.	10/31/11 10/31/11 12/07/11

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F 329	Continued From page 10 at 12:30 PM confirmed that the facility failed to monitor R23's use and effectiveness of the Ambien.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334		

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F 334	Continued From page 11 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedures and interview it was determined that the facility failed to have documentation that 2 (R108 and R109) out of 37 sampled residents were provided education about the usage and	F 334	**Tag Number:** F334 **1. Resident affected by the deficient practice.** R108 responsible party was sent 2011 influenza consent. **Other residents have potential to be affected.** All residents have potential to be affected. Procedural change to correct deficient practice. **Systemic change.** 2011 influenza consents sent to residents or responsible parties. Signed consents will be logged into EHR & original consent will be maintained in business office. **Monitoring.** Administrative Area will maintain list of consents received. Monthly audits of business file will occur for 3 months.	09/12/11 09/12/11 09/12/11 12/07/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. BUILDING _____ B. WING _____	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE AT LOFLAND PARK	715 E. KING STREET SEAFORD, DE 19973

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F 334	Continued From page 12 benefits of the flu vaccination. There was no evidence that R108 was offered the flu vaccine. Findings include: The facility policy and procedure for "Influenza and Pneumococcal Vaccinations" stated "All patient/residents identified as candidates to receive the Influenza and/or the Pneumococcal vaccinations will be offered the vaccination during their stay upon completing the following: answering "NO" to all questions on the Consent for Influenza/Pneumococcal Vaccination, receiving education about the vaccinations, and signing the consent form." 1. Review of R108's record failed to have documentation indicating that R108 received the flu vaccine in 2010 or that he refused the vaccine. Further review of R108's record failed to have documentation that R108 or his responsible party received education concerning the flu vaccine. 2. Review of R109's record revealed the administration of the flu vaccine but failed to have documentation indicating that R109 or her responsible party was provided education for the administration of the flu vaccine in 2010. On 9/6/11 at 10:15 AM review of R108's and R109's record with E15 (RN) confirmed that the facility failed to have documentation indicating these residents or their responsible parties were provided education and gave consent/refusal for the 2010 flu vaccine for these two residents.	F 334	**Tag Number:** F334 **2. Resident affected by the deficient practice.** R109 responsible party was sent 2011 influenza consent. **Other residents have potential to be affected.** All residents have potential to be affected. Procedural change to correct deficient practice. **Systemic change.** 2011 influenza consents sent to residents or responsible parties. Signed consents will be logged into EHR & original consent will be maintained in business office. **Monitoring.** Administrative Area will maintain list of consents received. Monthly audits of business file will occur for 3 months.	09/12/11 09/12/11 09/12/11 12/07/11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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LIFECARE AT LOFLAND PARK	715 E. KING STREET SEAFORD, DE 19973

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F 371	Continued From page 13 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation of the lunch meal in the garden unit on 08/30/11 and review of the small refrigerators in the first and second floor kitchenettes on 09/07/11, it was determined that staff failed to handle food in a sanitary manner and the facility failed to store food at the proper cold holding temperature. Findings include: 1. On 08/30/11 at 12:25, E8 (C.N.A) was assisting resident R60 with lunch. E8 picked up the chicken patty sandwich without putting on gloves and handed it to R60 to eat. R60 began eating the sandwich. Later, at 12:36, this practice was repeated between the aide and the resident. 2. On 09/07/11, observation revealed that the small refrigerator located in the first floor kitchenette, used to store cheese, butter, milk, sliced beef, and condiments, was holding at 46.8 degrees Fahrenheit (F) at 10:04 AM. This refrigerator failed to be at the required 41 degrees or below. The internal thermometer for this refrigerator was reading 54 degrees F. 3. On 09/07/11, observation revealed the small refrigerator located in the second floor	F 371	**Tag Number:** F371 **1. Resident affected by the deficient practice.** Unit Director addressed staff on Garden Unit at September staff meetings. **Other residents have potential to be affected.** All residents have the potential to be affected. Food Service Team Leader completed in-service to Garden Unit staff. **Systemic change.** All staff will complete Food Safety & Sanitation SLP. **Monitoring.** Random weekly observation audits will occur in each dining area for 3 months.	09/30/11 10/03/11 10/31/11 12/07/11

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F 371	Continued From page 14 kitchenette, used to store cheese, butter, milk, and condiments, was holding at 44.6F at 10:55 AM. This refrigerator failed to be at the required 41 degrees or below. The internal thermometer for this refrigerator was reading 50 degrees F.	F 371	**Tag Number:** F371 **2 & 3. Resident affected by the deficient practice.** Refrigerator was repaired to maintain temperature at or below 41 degrees.	09/09/11
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**Other residents have potential to be affected.** All six small refrigerators in various locations throughout the facility had the potential to be affected. Facilities assistant secured control knob at a setting that will maintain temperature at or below 41 degrees.	09/09/11
			Systemic change. All staff will complete Food Safety & Sanitation SLP.	10/31/11
	This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R48 and R177) out of 37 sampled residents it was determined that the pharmacist failed to report the lack of side effect monitoring for psychoactive medications. Findings include: 1. Cross refer F329 example 2. R48 was readmitted to the facility on 7/11/11 with orders for the anti-psychotic medication seroquel 75 mg in the morning and 100 mg at bedtime. There was no AIMS testing done upon re-admission as indicated by the facility's policy for AIMS testing.		**Monitoring.** Weekly audits of all small refrigerators will be conducted for 3 months. **Tag Number:** F428 **1. Resident affected by the deficient practice.** AIMS test completed for R48. **Other residents have potential to be affected.** All residents have potential to be affected. Copy of pharmacy deficiency provided to consultant pharmacist.	12/07/11 09/01/11 09/29/11

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F 428	Continued From page 15 The consultant pharmacist E9 reviewed the record on 8/4/11 and had no issues. The pharmacist filled to identify the lack of AIMS testing. The was confirmed by interview with the unit manager E21 on 9/6/11. 2. Cross refer F329 example 3. R177 was ordered the anti psychotic medication seroquel 25 mg qd (every day) on 6/9/11. No AIMS test could be located for the initiation of the anti-psychotic medication. This was confirmed by interview on 9/2/11 with the unit manager E7. Review of the consultant pharmacist (E9) records indicated R177 was reviewed on 6/28, 7/26, and 8/3/11. The pharmacist failed to identify of lack of AIMS testing upon initiation of the anti psychotic medication, seroquel.	F 428	**Systemic change.** Consultant Pharmacy Report for residents receiving psychoactive medications will be reviewed in monthly Behavior/Psychoactive Medication Meeting. All nurses will complete Medication Safety SLP. **Monitoring.** Audits will be completed monthly for 3 months for all residents receiving psychoactive medications requiring AIMS testing. **Tag Number:** F428 **2. Resident affected by the deficient practice.** AIMS test completed for R177.	10/31/11 12/07/11 09/25/11
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	**Other residents have potential to be affected.** All residents have potential to be affected. Copy of pharmacy deficiency provided to consultant pharmacist. **Systemic change.** Consultant Pharmacy Report for residents receiving psychoactive medications will be reviewed in monthly Behavior/Psychoactive Medication Meeting. All nurses will complete Medication Safety SLP.	09/29/11 10/31/11

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F 431	Continued From page 16 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based upon observation and interview during the medication storage review, it was determined that the facility failed to provide safe handling (including disposition) of all medication and accurate labeling to ensure safe administration of medications. Findings include: 1. On 9/2/11 at 10:05 AM, an observation was made in the 1st floor medication room refrigerator which contained 3 IV antibiotic bags, two of which expired on 8/26/11. The order had been discontinued for the resident. When reviewed with E22 (LPN), she confirmed that the IV antibiotics were expired.	F 431	**Tag Number:** F428 **Monitoring.** Audits will be completed monthly for 3 months for all residents receiving psychoactive medications requiring AIMS testing. **Tag Number:** F431 **1, 2, & 3. Resident affected by the deficient practice.** All expired medications disposed of. **Other residents have potential to be affected.** All medications have the potential to be affected. Education will be provided to correct deficient practice. **Systemic change.** All nurses will complete Medication Safety SLP, which includes proper medication maintenance & storage. **Monitoring.** Weekly audits will be conducted for 3 months.	12/07/11 09/02/11 10/31/11 10/31/11 12/07/11

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F 431	Continued From page 17 2. Upon examination of the treatment cart @ 1100 AM, there were 6 topical medications correctly identified with the residents names but no dates of when they were opened. 3. On 9/2/11 from 11:17 AM to 1:05 PM, an observation was made of the second floor medication room. The 2nd floor medication refrigerator contained an open TB vaccine vial without an open date. Four out of five medication carts contained open insulin multi-use containers without an open date listed as follows: Cart #1 2- Novolog Pen (28 day use) Cart #2 Levemir Pen (42 day use) Cart #3 Novolin 70/30 vial (30 day use) Long Term Care Cart #1 Lantus Pen (28 day use) A review of these findings was presented to the E1 (Administrator) and E2 (DON) on 9/7/11 at approximately 2:30 PM.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	Continued From page 18 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedures revealed the facility failed to ensure that the glucometer (Whole Blood Glucose Monitoring System Meter) was cleaned between residents to prevent the spread of infection in the facility. Findings include: The facility's policy and procedures for "Glucose,...Whole blood Glucose Monitoring System" revealed under C. "Performing a Blood Test: P. If the meter is not dedicated to a single patient, clean and disinfect the meter after every	F 441	**Tag Number:** F441 **Resident affected by the deficient practice.** Informal education provided by Unit Director regarding proper cleaning of glucometer between use on 09/07/11. Unit Director addressed topic at September staff meetings. **Other residents have potential to be affected.** All residents receiving FSBS have the potential to be affected. Education & competency for nursing staff being revised to focus on infection control practices for glucometers. **Systemic change.** All nursing staff will receive re-education for infection control practices for glucometer use. **Monitoring.** Random observational audits will occur weekly for 3 months.	09/21/11 10/07/11 10/31/11 12/07/11

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F 441	Continued From page 19 use...." On 9/1/11 a medication pass observation was done. E17 (RN) was observed at 11:50 AM using a glucometer to achieve R58's blood glucose level before administering his insulin. When E17 was done she put the glucometer on top of the medication cart and did not clean it. At approximately 12:10 PM E17 was observed using the same glucometer to check R32's blood glucose level without cleaning the glucometer. During a review of the medication pass observation with E17 on 9/7/11 at 11:50 am E17 confirmed she failed to clean the glucometer between resident use. This facility failure in an infection control practice has the potential to infect multiple residents in the facility.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Life Care at Lofland Park

DATE SURVEY COMPLETED: September 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from August 30, 2011 through September 7, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and five (105). The survey sample totaled thirty-seven (37) residents.	
3201	**Regulation for Skilled and Intermediate Nursing Facilities**	**3201.1.2**
3201.1.0	**Scope**	**Cross-refer: F279** Anticipated Date of Correction: 10/07/2011
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey report date completed 9/7/11, F279, F318, F329, F334, F371, F428, F431 and F441.	**Cross-refer: F318** Anticipated Date of Correction: 10/31/2011 **Cross-refer: F329** Anticipated Date of Correction: 10/07/2011 **Cross-refer: F334** Anticipated Date of Correction: 09/12/2011 **Cross-refer: F371** Anticipated Date of Correction: 10/31/2011 **Cross-refer: F428** Anticipated Date of Correction: 10/31/2011 **Cross-refer: F431** Anticipated Date of Correction: 10/31/2011 **Cross-refer: F441** Anticipated Date of Correction: 10/31/2011

Tawanya Demus, Ed. D., NHA Administrator 10/3/2011